STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 7/16/17 Investigation of a facility complaint # 68826-C and a facility mandatory #68839-M resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/14/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted 7/19/17 KW mmmm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to review and revise a resident's care plans to reflect the individual care provided by the staff for 1 of 4 residents reviewed (Resident #1). The facility identified a census of 75 residents.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 Findings include: The Minimum Data Set (MDS) assessment dated 4/19/17 recorded that Resident #1 had diagnoses that included muscle weakness, difficulty walking and dysphonia (difficulty speaking). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognitive and memory impairment. The resident required the assistance of 2 staff with transfers and did not walk during the assessment period. The resident's Care Plan dated 2/15/17 indicated the resident as at risk for falls. The Care Plan instructed staff s/he required the assistance of 2 staff with transfers and used Hoyer (mechanical) lift as needed (PRN). Observation on 6/22/17 revealed a Care Card hanging in the resident's closet in his/her room. The Care Card documented Resident #1 required a Hoyer lift device and extensive assistance of 2 staff with transfers. During an interview 6/22/17 at 12:36 p.m., Staff B , Certified Nursing Assistant (CNA) stated he had been informed the resident utilized a Hoyer lift device PRN and otherwise the resident had been a 2 person staff assist with transfers. During an interview 6/22/17 at 3:25 p.m., Staff C, CNA stated the resident had been strictly a Hoyer lift for all transfers. During an interview 6/28/17 at 1:18 p.m., Staff D, CNA confirmed the resident had been a Hoyer lift for all transfers.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 During an interview 6/28/17 at 4:23 p.m., Staff E, CNA stated the resident required a Hoyer lift for all transfers. During an interview 6/28/17 at 12:25 p.m., the Director of Nursing stated the MDS Coordinator updated both the Care Cards and the resident's Care Plan as to transfer status.	F 279		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews with staff, family and a wound care nurse and review of the facility policy and procedures, the facility failed to promote healing of a pressure sore for 1 of 4 residents reviewed and failed to provide measures to reduce the potential for the development of additional or worsening pressure	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 4 ulcers for 1 of 4 residents reviewed with pressure sores (Resident #5). The facility identified a census of 75 residents. Findings include: Resident #5 had a Minimum Data Set (MDS) assessment with a reference date of 4/5/17. The MDS indicated Resident #5 had diagnosis that included diabetes mellitus (DM), hemiplegia or hemiparesis and with multiple sclerosis (MS). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15. A score of 15 identified no problems with cognition. The MDS indicated the resident required extensive assistance of staff with bed mobility, transfers and personal hygiene and did not ambulate. The assessment indicated the resident had a bladder indwelling catheter, occasionally incontinent of bowels and at risk for pressure ulcers. The resident had no current ulcer areas and the resident did not have a turning/repositioning program. A Care Plan dated 4/19/17 indicated the resident had problems that included a chronic excoriation to his/her buttock area and at risk for other skin breakdown because of limited mobility and required assistance with his/her activities of daily living (ADL's) because of limited mobility from a diagnosis of MS. The approaches included the following: a. I liked to sleep in my recliner, but I had a bed in my room that may have been used for repositioning. b. I had a pressure reduction cushion on my bed and in my wheel chair (w/c). c. I liked to sit in my recliner after lunch.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 5 d. ROHO cushion to the recliner. e. I required 2 staff assistance to reposition frequently. f. I used adaptive devices per physical therapy (PT) and occupational therapy (OT) recommendations. Review of Non-Pressure Skin Condition Report forms revealed the following documentation as dated: Right buttock: On 4/26/17 - area closed On 5/3/17 - closed On 5/10/17 - closed On 5/17/17 - closed On. 5/24/17 - 2.0 centimeters (cm) by (x) 2.0 cm, superficial depth, no exudate, tunneling or odor, wound bed with epithelial and granulation tissue and pink surrounding skin and normal surrounding wound edges. On 5/31/17 - 0.3 cm x 0.3 cm, superficial depth, no exudate, tunneling or odor, wound bed with granulation tissue and pink surrounding skin and normal surrounding wound edges. On 6/7 - 2.6 cm x 2.4 cm, superficial depth, no exudate, tunneling or odor, wound bed with epithelial and granulation tissue and pink surrounding skin and normal surrounding wound edges. On 6/14/17-13.0 cm x 7.4 cm, superficial depth, a small amount of serosanguinous (blood and serum) exudate, no tunneling or odor, wound bed with epithelial and granulation tissue and pink surrounding skin and normal surrounding wound edges. Left buttock:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6 On 5/24/17- 2.2 cm x 2.0 cm, superficial depth, no exudate, tunneling or odor, wound bed with epithelial and granulation tissue and pink surrounding skin and normal surrounding wound edges. On 5/31 - 1.7 cm x 0.4 cm, superficial depth, no exudate, tunneling or odor, wound bed with granulation tissue and pink surrounding skin and normal surrounding wound edges. On 6/7 - 2.8 cm x 1.0 cm, superficial depth, no exudate, tunneling or odor, wound bed with granulation tissue and pink surrounding skin and normal surrounding wound edges. On 6/14 - 8.0 cm x 3.5 cm, superficial depth, a small amount of serosanguinous exudate, no tunneling or odor, wound bed with granulation tissue with pink surrounding skin and normal surrounding wound edges. Review of a Wound Care Consult note dated 6/19/17 at 11 a.m. included the following documentation: The resident had a 13 cm x 13 cm unstageable pressure ulcer on his/her sacrum with the right side having had the most involvement of necrotic tissue. There had been more superficial open areas on the periphery but the 13 cm measured the entire area involved. Staff reported the ulcer area came on very quickly. The patient reported he/she sat in his/her chair much of the time and slept in his/her recliner. The resident had a ROHO cushion in both of the chairs; however, the ROHO cushion in the recliner had been flat in the back right corner of the cushion. Staff reported the cushion flat for a while.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 Review of a Wound Care Consult note dated 6/19/17 from 11:15 a.m. until 12:00 p.m. included the following documentation: The wound care nurse consulted with 2 physicians upon her/his return to the hospital. One physician felt the resident needed a gastrointestinal and plastic surgery consult but it had been more than he wanted to take on due to the possible involvement of the rectal mucosa. The wound care nurse then spoke with another physician who felt the resident needed a specialist to take care of the issue and felt the patient should have been brought to the emergency room at the local hospital in preparation for a transfer to a larger facility. An Emergency Physician Documentation form dated 6/19/17 at 1:52 p.m. included the following documentation: A 65 year old male/female presented to the emergency department (ED) day with a large decubitus ulcer on the buttocks and the peril rectal area. He/she stated that area had gone from a small area of breakdown to the large area of breakdown in about a week. Apparently the area healed up and doing well prior. Not only had there been breakdown of the skin surrounding the rectal area, there appeared to have been involvement of the rectal mucosa as it almost looked like the anus and rectum had been dissected away from the surrounding tissue. Due to his/her MS he/she had been confined to a wheelchair. He/she slept in a recliner at night. The resident also had a ROHO cushion present in both of the chairs but 1 had been partially deflated. A wound assessment in the ED dated 6/19/17 at 1:12 p.m. included the following documentation:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 A necrotic pressure ulcer that measured 13 cm x 13 cm, depth at full thickness and a scant amount of yellow/tan drainage. The MDS described pressure sores as the following: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. During an interview on 6/23/17 at 12 p.m., the wound care nurse confirmed the following: The wound care nurse received a call on 6/19/17 and reported the resident had a black area on his/her bottom so she asked the staff to lay the resident down. She arrived at the facility, observed the large, black eschar covered wound and felt the area significant and she knew she could not treat the area. The nurse took a picture to show the physicians at the hospital. She then returned to the hospital and consulted with	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9	F 314		

physicians who both agreed the resident needed to have been treated. It was determined the pressure areas could have started 10 days to 2 weeks prior. The wound nurse stated the area had been avoidable as she thought the deflated ROHO cushion caused the injury. She indicated where the right posterior portion of the ROHO cushion had been deflated caused a ridge which resulted in the tissue damage to the anal area and the increase in size of the pressure area. Because of the resident's neuropathy related to the MS, the resident had a decline in pain receptors at the site so the facility should have intervened.

During an interview 6/27/17 at 2:30 p.m., the Administrator, Director of Nursing (DON) , Corporate Nurse Consultant and Staff A, Registered Nurse (RN) conducted a re-enactment of positioning on a ROHO cushion with a deflated right posterior quadrant at which time the Corporate Nurse Consultant felt the pressure would have been on the resident's left buttock not the right.

During an interview 6/27/17 at 2:34 p.m., the wound care nurse confirmed she did not agree with the facilities theory because the resident would have been leaning towards the right side and sitting funny with his/her left side up and right side down which would have caused pressure on the sacral area. The wound care nurse re-iterated the cause of the deterioration in the pressure ulcer area had been caused from the deflated ROHO cushion.

During an interview 6/28/17 at 11:16 a.m., a Physician confirmed if the wound care nurse stated the cause of the pressure ulcer had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10 from the deflated ROHO cushion she believed what she said as the wound care nurse had been right on it and she trusted her judgement. During an interview on 6/23/17 at 11:05 a.m., the DON stated the resident frequently requested the Physical Therapist Assistant (PTA) to check and inflate his/her ROHO cushion in the wheelchair but not the recliner. During an interview 6/27/17 at 1:29 p.m., the Occupational Therapist (OT) confirmed she had not checked the inflation rates on the ROHO cushions utilized in the facility and that it had been the nursing departments responsibility. During an interview 6/27/17 at 12:35 p.m., the PTA confirmed the resident had gone into the therapy room when he/she felt the ROHO cushion in his/her wheelchair had been getting low and he inflated the device, however, he never checked the ROHO in the resident's recliner and had not known he/she had one. The ROHO group shape fitting technology form (not dated) identified "Caution" areas as follows: a. Deflation: Failure by you to protect cushion or misuse of the cushion could have caused loss of air and resulted in bottoming out and/or pressure sores if not immediately fixed. b. Bottoming out: Failure by you to determine if any part of the individual had been touching the cushion base (too much air released) would decrease therapeutic value of the cushion and could have caused pressure sores. The product must have been adjusted to 1/2 inch (1 cm) of air laid between the support surface and lowest bony prominence. According to a Pressure Ulcer Skin Assessments	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 form dated January 2015, the purpose included the following: a. To promote the healing of pressure ulcers.	F 314		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews and review of the policy and procedures, the facility failed to transfer Resident #1 in a safe and secure manner and failed to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

protect against hazards in the environment which resulted in multiple skin tears and bruising. The sample consisted of 4 residents and the facility reported a census of 75 residents. The Care Card (located in the resident's room) directed the staff to use a Hoyer (mechanical) lift and 2 staff members to transfer the resident. The facility staff member manually lifted the resident from the wheelchair, the resident became uncooperative and obtained skin tears and bruising on the bed side rails of the bed.

Findings include:

Resident #1 had a Minimum Data Set (MDS) assessment with a reference date of 4/19/17. The assessment identified the resident had diagnosis that included muscle weakness, difficulty walking and dysphonia (difficulty speaking due to a physical disorder). The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5. A score of 5 indicated the resident had a severe cognitive impairment. The MDS indicated the resident required extensive assistance of 2 staff members with transfers and did not ambulate.

A Care Plan dated 2/15/17 identified the resident at risk for falls. The approaches included the following:

The resident required 2 staff to assist with transfers. The resident uses a Hoyer lift (mechanical left) device as needed (PRN).

On 6/22/17 (time unknown), observation identified a Care Card hanging in the resident's closet in his/her room. The documentation on the card identified the resident required a Hoyer lift for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 transfers and the assistance of 2 staff members. An Incident/Accident/Unusual Occurrences Form dated 6/8/17 at 9 p.m. documented the resident was raised with a Hoyer lift device but when the device stopped, he/she started to kick and fight (per the Certified Nursing Assistant (CNA). This resulted in 2 skin tears to the right knee and U shaped. One measured 1 centimeters (cm) X (by) 3.5 cm and the other 1 cm x 6 cm. On 6/9/17 (time unknown) the Assistant Director of Nursing (ADON) spoke with Staff B, CNA who stated the resident was fine until he/she began lifted up in the Hoyer lift. The resident then started freaking out, yelling and flailing his/her arms and kicking his/her legs. The staff member was positioned behind the resident and then went to the side to try and provide safety to the resident. The resident was laid in bed and staff noticed the skin tear to the right knee. The staff indicated the skin tear was from failing. During an interview 6/22/17 at 12:36 p.m., Staff B, CNA confirmed he self transferred the resident independently from the wheel chair (w/c) to the bed without the use of a Hoyer lift device. The staff member stated as he started to transfer the resident, he/she became uncooperative and tried to kick him but ultimately ended up kicking the side rail on the bed which caused the skin tears to the right knee. The resident began to yell help so Staff C entered the room and assisted to position the resident in bed. Staff B stated he was informed the resident utilized a Hoyer lift device PRN and otherwise the resident required 2 person staff assistance with transfers. During an interview on 6/22/17 at 3:25 p.m., Staff C, CNA confirmed she heard the resident yelling	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

for help so she opened the resident's door and observed Staff B as he self transferred the resident to bed without the use of a Hoyer lift device. When the resident observed Staff C he/she kept saying help me, help me. Staff C placed her hands under the resident's thighs and calves as Staff B supported the resident's upper body and positioned the resident in bed at which time she noticed 3 skin tears on the resident's right knee. The staff member confirmed the resident had been strictly a Hoyer lift with all transfers.

During an interview on 6/22/17 at 3:25 p.m., Staff C, CNA confirmed the resident as strictly a Hoyer lift for all transfers.

During an interview on 6/28/17 at 1:18 p.m., Staff D, CNA confirmed the resident required a Hoyer lift for all transfers.

During an interview on 6/28/17 at 4:23 p.m., Staff E, CNA confirmed the resident required a Hoyer lift for all transfers.

Review of Non-Pressure Skin Condition Report forms identified the following documentation as dated:

On 6/8/17- A skin tear on the resident's right knee measured 6 cm, with no depth, a scant amount of serosanguinous drainage, no odor, normal skin in the wound bed and normal surrounding skin and wound edges.

On 6/8/17- A skin tear on the resident's right knee that measured 3.5 cm, with no depth, a scant amount of serosanguinous drainage, no odor, normal skin in the wound bed and normal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 surrounding skin and wound edges. On 6/9/17- A skin tear on the resident's right middle knee that measured 2.5 cm x 0.1 cm, with no depth, no drainage, no odor, bruised surrounding skin and peripheral tissue edema on the wound edges. On 6/9/17-A bruise on the resident's left inner forearm measured 7.8 cm x 8.6 cm, with no depth, drainage or odor and normal surrounding skin and wound edges. On 6/9/17- a bruise on the resident's left upper arm measured 5.4 cm x 4.1 cm, with no depth, drainage or odor and normal surrounding skin and wound edges. On 6/9/17- A bruise on the resident's left inner wrist measured 1.6 cm x 4.0 cm, with no depth, drainage or odor and normal surrounding skin and wound edges. On 6/12/17- A bruise on the resident's left shin measured 20.6 cm x 25.2 cm, with no depth, drainage or odor and normal surrounding skin and wound edges. On 6/12/17 - A bruise on the resident's right upper arm that measured 1.9 cm x 3.9 cm, with no depth, drainage or odor and normal wound bed, surrounding skin and wound edges. On 6/12/17- A bruise on the resident's posterior upper right leg that measured 5.9 cm x 0.8 cm, with no depth, drainage or odor and normal wound bed, surrounding skin and wound edges. On 6/12/17- A bruise on the resident's right shin	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165288	A. BUILDING _____ B. WING _____	C 06/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SPECIALTY CARE	1300 EAST 19TH STREET ATLANTIC, IA 50022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 that measured 10.5 cm x 4.3 cm, with no depth, drainage or odor and normal wound bed, surrounding skin and wound edges. On 6/12/17- A bruise on the resident's right lower wrist measured 3.9 x 3.9 cm, with no depth, drainage or odor and normal wound bed, surrounding skin and wound edges. During an interview on 6/28/17 at 12:45 p.m., the Director of Nursing (DON) confirmed she felt all bruising from 6/9/17 and 6/12/17 had been a result of the staff member self transferring the resident on 6/8/17. The facility policy and procedures titled Lift - Mechanical, dated January 2015, the purpose of the mechanical lift is to provide a safe transfer for non-ambulatory residents.	F 323		

F 279

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 279. This allegation does not constitute guilt but that the facility is in compliance to F 279. This is my credible allegation of compliance with date certain of 7/16/17.

Resident #1 has had their care plan and care card reviewed. Both reflect the correct level of care needed regarding transfers to meet the resident needs to assist in ensuring safe transfers.

All residents had their care plans and care cards reviewed to ensure both match so that staff know the correct transfer assist needed for the residents.

Staff was educated on *6/27/17* on the facility transfer policy. Staff were educated on *6/27/17*on where to find the correct transfer information for the residents.

Facility will continue to update care plans with each MDS as well as the care cards to ensure that they match. Care plans and care cards will also be reviewed with change in resident status to ensure that they are updated as the residents level of care changes to assist in keeping residents safe and that they receive the care needed.

The facility's QA process will monitor that care plans and care cards are updated and match as part of their QA duties. Care plans and care cards will be updated as needed and staff will be informed of changes to care plans and cards so that they can continue to provide the proper care to meet the resident's needs.

F 314

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 314. This allegation does not constitute guilt but that the facility is in compliance to F 314. This is my credible allegation of compliance with date certain of 7/16/17.

Resident #5 has a new pressure relief cushion in place that does not require monitoring of correct air pressures. This new cushion will be used in both the resident's wheel chair and recliner.

The facility removed all ROHO (Air cushions) from the facility. The facility replaced those cushion with new pressure relief cushions that do not require monitoring of air pressures. All residents continue to be

assessed via use of Braden scores to establish risk status for skin breakdown to assist in determining what type of pressure relief would best suit that resident. Care Cards/Care plans were updated for all residents so staff know if a resident needs a pressure relief cushion in their wheelchair and or room chair.

Staff was educated on upon hire and during prior inservices on the fact that all pressure relieving devices are listed on resident care plans and care cards. Staff was re-educated on *6/27/17* where required pressure relief devices for resident are listed. Resident risk status for skin breakdown will continue to be monitored via use of the Braden Scores. These assessments will be updated with each MDS and as needed with change in resident's status. Direct care staff will be educated if changes to care plans and or care cards were made so that they know of new pressure relief measures were put into place.

The facility's QA process will monitor that correct pressure relief measures are in place per their QA rounds. Problems with devices will be corrected at that time. The facility will continue to have scheduled skin meetings. Care plans and care cards will be reviewed at that time as well as input from Dietician and Therapy to assist in wound heling as well as proper body positioning to assist in pressure relief and or wound healing is achieved.

F 323

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

This is my credible allegation of compliance to F 323. This allegation does not constitute guilt but that the facility is in compliance to F 323. This is my credible allegation of compliance with date certain of 7/16/17.

Resident #1 is being transferred per facility protocol with a mechanical lift with the assist of 2 staff. The staff member who chose to transfer resident #1 without a mechanical lift is no longer employed at that facility.

All residents who require a mechanical lift are being transferred per facility protocol. All residents who require staff assistance with transfers are being transferred per their care plans and care cards to ensure that transfers are safe and that the resident's needs are being met.

Staff was educated on *6/27/17* on the facility's transfer protocol as well as the facility's mechanical lift protocol requiring 2 staff to use a mechanical lift. Care plans and care cards were reviewed to ensure proper information was located in both places so that staff knows the transfer requirements for each resident. Care plans and care cards will be reviewed with each MDS and resident status changes to ensure proper transfer requirements are available for each resident. Staff will be informed of care plan

and care card changes. Facility's nurse manager will audit staff to ensure proper transfer techniques are followed. Problems will be corrected as they are observed.

The facility's QA process will monitor that transfer audits occur and that care plans and care cards are reviewed so that residents are safe during the transfer process. Problems will be corrected as they are observed.